When is a hernia not a hernia and lymphoma not lymphoma?

Matthew Hamill and Mags Curtiss, The Garden Clinic, Berkshire Healthcare NHS Foundation Trust

We present a case of anorectal LGV masquerading as an incarcerated inguinal hernia. At surgery inguinal lymph nodes were discovered, a histopathological diagnosis of polymorphic lymphoproliferative disorder made and the patient referred for evaluation to consider chemotherapy.

During this time the patient attended his local GUM/HIV clinic and a rectal swab was positive for LGV. The lymphadenopathy resolved after treatment with oral doxycycline.

The case serves as a reminder to non-GUM colleagues to consider STI as a cause of inguinal lymphadenopathy.

Background/introduction:

Lymphogranuloma venereum (LGV) is a sexually transmitted infection (STI) caused by one of three invasive serovars (L1, L2 or L3) of *Chlamydia trachomatis*. Molecular epidemiological studies have identified L2 as the main serovar causing the current outbreaks in Europe and North America⁽¹⁾.

In recent men who have sex with men (MSM) outbreaks in Europe, more than 95% of all cases presented with proctitis; symptoms included rectal pain, anorectal bleeding, mucoid and/or purulent rectal discharge, tenesmus, constipation and other symptoms of lower gastrointestinal inflammation⁽¹⁾.

However other symptoms and signs may present, and unless a careful sexual history is taken STI may not be considered in the differential diagnosis of gastrointestinal or lymphoid pathology.

Aim(s)/objectives:

To illustrate the potential for mis/inaccurate diagnosis of groin swellings in sexually active MSM and provide a case that can be used for teaching primary care, surgical, oncology and histopathology colleagues.

Results:

The patient underwent open surgery to repair an inguinal hernia. At surgery he was found to have significant inguinal lymphadenopathy⁽²⁾. Histopathological analysis at the regional pathology centre identified a likely B cell lymphoma and referral was made to haematology to consider anti-cancer therapy. In the interim the patient attended our GUM service, was diagnosed with rectal LGV and treated with antibiotics. His lymphadenopathy resolved and staging CT was negative.

Case:

A 55 year old known HIV-positive MSM (CD4 count: 690; VL: undetectable on truvada & darunavir/ritonavir) attended the GUM clinic presenting with abdominal 'gassy' symptoms, associated with weight loss and an 'anal fissure' but no diarrhoea. 2 weeks previously he presented to the surgical team who had diagnosed an incarcerated inguinal hernia. At surgery no hernia was found but an enlarged inguinal LN was excised. Histological examination was reported as 'polymorphic lymphoproliferative disorder'.

On examination in the GUM clinic he had a painful perianal fissure and 2x3 cm inguinal lymph nodes. No other lymph nodes were palpable. Rectal NAATS were positive for LGV.

After 2 weeks of doxycycline treatment his LNs had begun to regress.

Discussion/conclusion:

Careful consideration of the differential diagnosis of inguinal swelling should be undertaken and STI excluded prior to general anaesthesia and operative procedures whenever possible. Had this patient not attended a GUM clinic he may have undergone unnecessary, potentially toxic chemotherapy.

This case illustrates the need for open communication between GUM and other medical colleagues.

In this case further investigation and treatment of a potential malignant condition was avoided by timely diagnosis and treatment of rectal LGV.

(1) 2013 UK National Guideline for the management of lymphogranuloma venereum . Clinical Effectiveness Group of the British Association for Sexual Health and HIV (CEG/BASHH) Guideline development group. J White1, N O'Farrell and D Daniels

(2) <https://www.studyblue.com/notes/note/n/10-23-perineum-gluteal-and-perineal-relations/deck/12606327>